LAKE ERIE COLLEGE
VARSITY ATHLETIC PHYSICAL: 2008-2009

Name: ____ Physical Date: ______/______/_________

Age: ________ Date of Birth: ______/______/__________ Social Security # _______-______-__________

Class: FR SO JR SR 5th Sports: ____

PREVIOUS MEDICAL HISTORY:

1. Has a doctor ever denied or restricted your participation in sports for any reason? YES NO
2. Do you have an ongoing medical condition (like diabetes or asthma)? YES NO
3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills? YES NO
4. Do you have allergies to medicines, pollens, foods or stinging insects? YES NO
5. Have you ever passed out or nearly passed out DURING exercise? YES NO
6. Have you ever passed out or nearly passed our AFTER exercise? YES NO
7. Have you ever had discomfort, pain or pressure in your chest during exercise? YES NO
8. Does your heart race or skip beats during exercise? YES NO
9. Has your doctor ever told you that you have (check all that apply):

   High blood pressure A heart murmur High cholesterol A heart infection

10. Has a doctor ever ordered a test for your heart? (i.e. ECG, echocardiogram) YES NO
11. Has anyone in your family died for no apparent reason? YES NO
12. Does anyone in your family have a heart problem? YES NO
13. Has any family member or relative died of heart problems or of sudden death before the age o 50? YES NO
14. Does anyone in your family have Marfan syndrome? YES NO
15. Have you ever spent the night in a hospital? YES NO
16. Have you ever had surgery? YES NO
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or muscle tendonitis, that caused you to miss a practice or game? YES NO
18. Have you had any broken or fractured bones or dislocated joints? YES NO
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches? YES NO
20. Have you ever had a stress fracture? YES NO
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? YES NO
22. Do you regularly use a brace or assistive device? YES NO
23. Has a doctor ever told you that you have asthma or allergies? YES NO
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? YES NO
25. Is there anyone in your family who has asthma? YES NO
26. Have you ever used an inhaler or taken asthma medicine? YES NO
27. Were you born without or are you missing a kidney, an eye, a testicle or any other organ? YES NO

28. Have you had infectious mononucleosis (mono) within the last month? YES NO
29. Do you have any rashes, pressure sores, or other skin problems? YES NO
30. Have you had a herpes skin infection? YES NO
31. Have you ever had a head injury or concussion? YES NO
32. Have you been hit in the head and been confused or lost your memory? YES NO
33. Have you ever had a seizure? YES NO
34. Do you have headaches with exercise? YES NO
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? YES NO
36. Have you ever been unable to move your arms or legs after being hit or falling? YES NO
37. When exercising in the heat, do you have severe muscle cramps or become ill? YES NO
38. Has a doctor ever told you that you or someone in your family has sickle cell disease? YES NO
39. Have you had any problems with your eyes or vision? YES NO
40. Do you wear glasses or contacts? YES NO
41. Do you wear protective eyewear, such as goggles or a face shield? YES NO
42. Are you happy with your weight? YES NO
43. Are you trying to gain or lose weight? YES NO
44. Has anyone recommended you change your weight or eating habits? YES NO
45. Do you limit or carefully control what you eat? YES NO
46. Do you have any concerns that you would like to discuss with the doctor? YES NO
47. Please rate your mental health status from a 1 (Poor) to 10 (Great). ______
48. Have you been under the care of a psychiatrist, psychologist, or counselor in the past 12 months? YES NO
49. Have you been prescribed any medications for mental health during the past 12 months? YES NO

FEMALES ONLY:

50. Have you ever had a menstrual period? YES NO
51. How old were you when you had your first menstrual period? _________
52. How many periods have you had in the last 12 months? _________

Please explain any "YES" answers here: ____

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____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

*Signature of Athlete:*____ *Date:* ____________________

PHYSICAL EXAM: ***Athlete's Name***: ______________________________

Height: __________ inches ***Weight***: __________ pounds ***Body Fat***: __________%

Pulse: ________ bpm ***Blood Pressure***: ______/_______ Re-checks: _______/______; _______/_______

Vision: Right 20/_______; Left 20/_______ Corrected? YES NO ***Pupils***: Equal _____ Unequal _____

	WNL	Abnormal Findings	Initials
General Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Cleared without restrictions

Cleared with recommendation for further evaluation or treatment for: ______________________________

____

Not cleared for: All sports Certain Sports: ______________________________

Reason: ____

Recommendations: ____

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____

Signature of physician: ______________________________ Date: ______________